

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – BCCS OFFICE VISITS		
99201	Office Visit - New Patient; <i>problem focused</i> history, exam, straightforward decision-making; 10 minutes	\$44.61
99202	Office Visit - New Patient; <i>expanded problem focused</i> history, exam, straightforward decision-making; 20 minutes	\$76.20
99203	Office Visit - New Patient; <i>detailed</i> history, exam, straightforward decision-making; 30 minutes	\$110.25
99204	Office Visit - New Patient; <i>comprehensive</i> history, exam, moderate complexity decision-making; 45 minutes.	\$168.36
99205	Office Visit - New Patient; <i>comprehensive</i> history, exam, high complexity decision-making; 60 minutes.	\$211.17
99211	Office Visit - Established Patient; <i>evaluation and management</i> , may not require physician; 5 minutes	\$20.33
99212	Office Visit - Established Patient; <i>problem focused</i> history, exam, straightforward decision-making; 10 minutes	\$44.27
99213	Office Visit - Established Patient; <i>expanded problem focused</i> history, exam, low-complexity decision-making; 15 minutes	\$74.42
99214	Office Visit - Established Patient; <i>detailed</i> history, exam, moderate complexity decision-making; 25 minutes	\$109.65
<ul style="list-style-type: none"> Office visits should only be billed for face-to-face interactions with a licensed, qualified provider, i.e. MD, APN, PA, or RN The CPT code billed for an office visit should be based on the level of complexity of the history, exam, and decision-making 99204, 99205, and 99214 are uncommon office visits for the typical services provided through the BCCS program. Utilization review is performed on office visits No more than 1 BCCS office visit is billable on the same day 99204 and 99205 must meet the criteria for the code. These codes are <u>not</u> appropriate for screening visits 99211 does not require physician presence, although client evaluation and/or management are required; 99211 cannot be billed for client phone calls or patient navigation. Consultation visits are billed using office visit codes and may be billed on the same day as the BCCS office visit Global fee periods apply to certain diagnostic surgical procedures. Office visits are not allowed to be billed separately during the global fee periods Global fee periods do not apply to consultations with a breast or cervical specialist See specific diagnostic CPT codes for any global fee periods that may apply Mammography facilities cannot bill for office visits Neither the program, nor the patient, can be billed for "no show" visits 		

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES		
77053	Mammary ductogram or galactogram, single duct, Global Fee	\$59.50
<ul style="list-style-type: none"> • May be billed with 77055, G0206, 77056, G0204, 76641, 76642 • Billable for clients with spontaneous nipple discharge and BI-RADS 1-3 after diagnostic mammogram • May not be billed with screening mammograms (77057, G0202, B7057, B0202) or MRI (77058, B7058, 77059, B7059) • BCCS performs utilization review on this service 		
77058	Magnetic Resonance Imaging, breast, with and/or without contrast, unilateral, Global Fee	\$543.98
77059	Magnetic Resonance Imaging, breast, with and/or without contrast, bilateral, Global Fee	\$543.98
<ul style="list-style-type: none"> • May only be reimbursed for clients with one or more of the following: <ul style="list-style-type: none"> -BRCA mutation; -a first-degree relative who is a BRCA carrier; -a lifetime risk of 20-25%, or greater, as defined by risk assessment models such as BRCAPRO/Gail Model; -radiation therapy to the chest between the ages of 10-30 years; -Li-Fraumeni syndrome, Cowden syndrome, or Bannayan-Riley-Ruvalcaba syndrome, or first-degree relatives with one of these syndromes. • May not be used alone as a breast cancer screening tool • May not be billed without breast screening mammogram • May be reimbursed with 77057, G0202 • May not be billed with B7059, B7059 or B0202 • May be billed with diagnostic mammograms used for additional views. • Must be performed in a facility with dedicated breast MRI equipment that can perform MRI guided breast biopsy • Preauthorization is required 		
B7058	Magnetic Resonance Imaging, breast, with and/or without contrast, unilateral (Age 40-49)	\$543.98
B7059	Magnetic Resonance Imaging, breast, with and/or without contrast, bilateral (Ages 40-49)	\$543.98
<ul style="list-style-type: none"> • May only be reimbursed for clients with one or more of the following: <ul style="list-style-type: none"> -BRCA mutation; -a first-degree relative who is a BRCA carrier; -a lifetime risk of 20-25%, or greater, as defined by risk assessment models such as BRCAPRO/Gail Model; -radiation therapy to the chest between the ages of 10-30 years; -Li-Fraumeni syndrome, Cowden syndrome, or Bannayan-Riley-Ruvalcaba syndrome, or first-degree relatives with one of these syndromes. • May not be used alone as a breast cancer screening tool • May not be billed without breast screening mammogram • May be reimbursed with B7057 and B0202 • May not be reimbursed with 77058, 77059, 77057 or G0202 • May be billed with diagnostic mammograms used for additional views • Must be performed in a facility with dedicated breast MRI equipment that can perform MRI guided breast biopsy. Preauthorization is required 		

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES		
77057	Screening Mammogram, Bilateral, Global Fee	\$83.83
G0202	Screening Mammogram, Digital, Bilateral, Global Fee	\$136.78
77055	Diagnostic Mammogram, Unilateral, Global Fee	\$91.45
G0206	Diagnostic Mammogram, Digital, Unilateral, Global Fee	\$131.34
77056	Diagnostic Mammogram, Bilateral, Global Fee	\$117.58
G0204	Diagnostic Mammogram, Digital, Bilateral, Global Fee	\$167.27
<ul style="list-style-type: none"> • A diagnostic mammogram can be performed as the initial screening mammogram for women with cosmetic/reconstructive implants and/or a history of breast cancer/lumpectomy • A screening mammogram, on occasion, may precede the Clinical Breast Exam, i.e. mobile mammograms • An imaging/mammography/radiology facility cannot be reimbursed for an office visit when a mammogram is the only service provided • Computer Aided Detection (CAD) in breast cancer screening or diagnostics is specifically not allowed by BCCS 		
B7057	Screening Mammogram, Bilateral, Global Fee (Age 40-49)	\$83.83
B0202	Screening Mammogram, Digital, Bilateral, Global Fee (Age 40-49)	\$136.78
<ul style="list-style-type: none"> • Must be used to bill screening mammograms for women 40 to 49 years of age • Women in this age group may receive a mammogram every two (2) years or annually if high risk per risk assessment tool – see breast clinical guidelines • The guidelines for 77057 apply to B7057. The guidelines for G0202 apply to B0202 		
19000	Puncture Aspiration of Breast Cyst	\$116.38
<ul style="list-style-type: none"> • 19000 may be billed once per breast regardless of the number of lesions • 19000 may be billed with 76942 • Pathology (88305 or 88173) may not be reimbursed with 19000 • Office visit codes on the day of the procedure are not payable (Global Fee Period 000) 		

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES		
19100	Breast biopsy, percutaneous, needle core, not using imaging guidance, one or more lesions (Physician in Office)	\$154.91
F9100	Breast biopsy, percutaneous, needle core, not using imaging guidance, one or more lesions (Physician in Facility)	\$72.94
100FX	Facility fee for needle core biopsy	\$526.74
<ul style="list-style-type: none"> • 19100 and F9100 may only be billed once per breast, regardless of the number of specimens • 19100 cannot be billed with 00400 or 100FX • Cannot bill with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes • 100FX may be billed with F9100; but only once • 00400 may be billed with F9100 and 100FX for the total anesthesia units provided, up to the 8 unit maximum • 88305 may be billed for up to 6 biopsy specimens per breast • Office visit codes on the day of the procedure are not payable (Global Fee Period 000) 		
19101	Incisional Breast Biopsy; one or more lesions (Physician in Office)	\$351.34
F9101	Incisional Breast Biopsy; one or more lesions (Physician in Facility)	\$230.20
101FX	Facility fee for incisional breast biopsy	\$1,223.47
<ul style="list-style-type: none"> • 19101 and F9101 may be billed only once (per breast) regardless of the number of lesions • 76098 (if indicated) may be billed for each lesion, up to the maximum of 3 per breast • 88305 may be billed for up to 6 biopsy specimens per breast • 101FX may be billed once with F9101 • 19101 cannot be billed with 00400 • 00400 may be billed with F9101 for the total anesthesia units provided, up to the 8 unit maximum • Cannot bill with 76641, 76642, 76942, screening/diagnostic mammogram or MRI codes • May be billed with image guided preoperative placement of breast localization devices 19281-F9288 and their associated facility codes • Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 010) 		

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES		
19120	Excision of abnormal breast tissue, duct, nipple or areolar lesion; one or more lesions (Physician in Office)	\$510.13
F9120	Excision of abnormal breast tissue, duct, nipple or areolar lesion; one or more lesions (Physician in Facility)	\$429.61
120FX	Facility fee for excisional breast biopsy	\$1,223.47
<ul style="list-style-type: none"> • May be billed only once per breast regardless of the number of lesions • 120FX may be billed once with F9120. 76098 may be billed if indicated for each lesion up to the maximum of 3 per breast • 88305 may be billed for up to 6 biopsy specimens per breast • 00400 cannot be billed with 19120 • 00400 may be billed with F9120 for the total anesthesia units provided, up to the maximum of 8 • May not be used with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes • May be billed with imaging guided preoperative wire placement (19281-F9288 and associated facility codes) • Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 090) 		
19125	Excision of abnormal breast tissue, duct, nipple or areolar lesion, single lesion; identified by preoperative placement of radiological marker (Physician in Facility)	\$477.58
125FX	Facility fee for excision of abnormal breast tissue, duct, nipple or areolar lesion/preoperative placement of radiological marker, single lesion.	\$1,223.47
19126	Excision of abnormal breast tissue, duct, nipple or areolar lesion, each additional lesion (Physician in Facility)	\$168.92
<ul style="list-style-type: none"> • 19125 may be billed only once per breast, regardless of the number of lesions • 19126 may only be billed for up to 2 additional lesions. • 125FX may be billed once with 19125 • 76098 may be billed if indicated for each lesion, up to the maximum of 3 • 88305 may be billed for up to 6 biopsy specimens per breast • 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum • May not bill with 76641, 76642, 76942 or codes for screening/diagnostic mammogram and MRI • 19125 may be billed with image guided preoperative wire placement (19281-F9288 and associated facility codes), if needed • For 19125-Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 090) • For 19126-Codes related to another service are always included in the global period of the other service (Global fee period ZZZ) 		

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES		
19081	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; <u>stereotactic guidance</u>; first lesion; Global Fee (Physician in Office)	\$714.41
F9081	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; <u>stereotactic guidance</u>; first lesion; Global Fee (Physician in Facility)	\$177.62
19082	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; <u>stereotactic guidance</u>; each additional lesion (Physician in Office)	\$591.13
F9082	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; <u>stereotactic guidance</u>; each additional lesion (Physician in Facility)	\$88.82
812FX	Facility fee for percutaneous breast biopsy using <u>stereotactic guidance</u>; one or more lesions	\$526.74
<ul style="list-style-type: none"> 19081 and F9081 can only be billed once per breast, regardless of the number of lesions 19082 and F9082 may be billed up to the maximum of 2 additional lesions per breast May not be billed with 19281-F9288 or associated facility codes 88305 may be billed for up to 6 biopsy specimens per breast 76098 may be billed for each lesion up the maximum of 3, if indicated 000400 cannot be billed with 19081 or 19082. May be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes 812FX may be billed with once with F9081 and F9082 Office visits not reimbursable on day of procedure. (Global fee period 000) 		
19083	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; <u>ultrasound guidance</u>; first lesion (Physician in Office)	\$690.90
F9083	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; <u>ultrasound guidance</u>; first lesion (Physician in Facility)	\$166.44
19084	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; <u>ultrasound guidance</u>; each additional lesion (Physician in Office)	\$568.75
F9084	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; <u>ultrasound guidance</u>; each additional lesion (Physician in Facility)	\$83.40
834FX	Facility fee for percutaneous breast biopsy using <u>ultrasound guidance</u>; one or more lesions	\$526.74
<ul style="list-style-type: none"> 19083 and F9083 may only be billed once per breast regardless of the number of lesions 19084 and F9084 may be billed up to the maximum of 2 additional lesions per breast May not be billed with 19281-F9288 or associated facility codes 88305 may be billed for up to 6 biopsy specimens per breast 76098 may be billed for each lesion up the maximum of 3, if indicated 00400 cannot be billed with 19083 or 19084 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes 834FX may be billed once with F9083 and F9084 Office visits not reimbursable on day of procedure 		

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BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES		
F9085	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; <u>magnetic resonance guidance</u>; first lesion Global Fee (Physician in Facility)	\$195.45
F9086	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; <u>magnetic resonance guidance</u>; each additional lesion Global Fee (Physician in Facility)	\$96.88
856FX	Facility fee for percutaneous breast biopsy using <i>MRI guidance, one or more lesions</i>	\$790.85
<ul style="list-style-type: none"> F9085 may only be billed once per breast regardless of the number of lesions May only be performed in a facility with dedicated breast MRI equipment. Preauthorization is required F9086 may be billed up to the maximum of 2 additional lesions per breast May not be billed with 19281-F9288 or associated facility codes 88305 may be billed for up to 6 biopsy specimens per breast 		<ul style="list-style-type: none"> 76098 may be billed for each lesion up the maximum of 3, if indicated 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or screening MRI codes 856FX may be billed once with F9085 Office visits not reimbursable on day of procedure
19281	Preoperative placement of breast localization device, percutaneous; <u>mammographic guidance</u>; first lesion (Physician in Office)	\$246.69
F9281	Preoperative placement of breast localization device, percutaneous; <u>mammographic guidance</u>; first lesion (Physician in Facility)	\$106.33
19282	Preoperative placement of breast localization device, percutaneous; <u>mammographic guidance</u>; each additional lesion (Physician in Office)	\$172.65
F9282	Preoperative placement of breast localization device, percutaneous; <u>mammographic guidance</u>; each additional lesion (Physician in Facility)	\$53.32
<ul style="list-style-type: none"> May only be billed with incisional/excisional biopsy and their associated facility codes Facility fees are included with the primary procedure code 19281 and F9281 may only be billed once per breast regardless of the number of lesions Additional lesions may be billed up to a maximum of 2 per breast Cannot be billed with 19081-F9086 or their associated facility codes 		<ul style="list-style-type: none"> Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes 00400 cannot be billed with 19281 or 19282 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum Office visits not reimbursable on day of procedure. (Global fee period 000)

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES		
19283	Preoperative placement of breast localization device, percutaneous; <u>stereotactic</u> guidance; <i>first lesion</i> (Physician in Office)	\$277.46
F9283	Preoperative placement of breast localization device, percutaneous; <u>stereotactic</u> guidance; <i>first lesion</i> (Physician in Facility)	\$106.99
19284	Preoperative placement of breast localization device, percutaneous; <u>stereotactic</u> guidance; <i>each additional lesion</i> (Physician in Office)	\$209.24
F9284	Preoperative placement of breast localization device, percutaneous; <u>stereotactic</u> guidance; <i>each additional lesion</i> (Physician in Facility)	\$54.01
<ul style="list-style-type: none"> May only be billed with incisional/excisional biopsies and their associated facility codes Facility fees are included with the primary procedure code 19283 and F9283 may only be billed once per breast regardless of the number of lesions Additional lesions may be billed up to a maximum of 2 per breast Cannot be billed with 19081-F9086 or their associated facility codes 		<ul style="list-style-type: none"> Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes 00400 cannot be billed with 19283 or 19284 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum Office visits not reimbursable on day of procedure. (Global fee period 000)
19285	Preoperative placement of breast localization device, percutaneous; <u>ultrasound</u> guidance; <i>first lesion</i> (Physician in Office)	\$530.71
F9285	Preoperative placement of breast localization device, percutaneous; <u>ultrasound</u> guidance; <i>first lesion</i> (Physician in Facility)	\$90.69
19286	Preoperative placement of breast localization device, percutaneous; <u>ultrasound</u> guidance; <i>each additional lesion</i> (Physician in Office)	\$467.07
F9286	Preoperative placement of breast localization device, percutaneous; <u>ultrasound</u> guidance; <i>each additional lesion</i> (Physician in Facility)	\$45.70
<ul style="list-style-type: none"> May only be billed with incisional/excisional biopsies and their associated facility codes Facility fees are included with the primary procedure code 19285 and F9285 may only be billed once per breast regardless of the number of lesions Additional lesions may be billed up to a maximum of 2 per breast Cannot be billed with 19081-F9086 or their associated facility codes 		<ul style="list-style-type: none"> Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes 00400 cannot be billed with 19283 or 19284 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum Office visits not reimbursable on day of procedure. (Global fee period 000)

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES		
F9287	Preoperative placement of breast localization device, percutaneous; <u>magnetic resonance</u> guidance; first lesion (Physician in Facility)	\$136.04
F9288	Preoperative placement of breast localization device, percutaneous; <u>magnetic resonance</u> guidance; each additional lesion (Physician in Facility)	\$67.87
<ul style="list-style-type: none"> Codes using magnetic resonance imaging may only be performed in a facility with dedicated breast MRI equipment Facility fees are included with the primary procedure code Preauthorization is required May only be billed with incisional/excisional biopsies and their associated facility codes F9287 may only be billed once per breast regardless of the number of lesions 		<ul style="list-style-type: none"> Additional lesions may be billed up to a maximum of 2 per breast Cannot be billed with 19081-F9086 or their associated facility codes Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or screening MRI codes 00400 may be billed with to reflect anesthesia units provided, up to the 8 unit maximum Office visits not reimbursable on day of procedure
00400	Anesthesia for procedures on the integumentary system, anterior trunk, not otherwise specified.	\$22.88
<ul style="list-style-type: none"> Bill for the total number of units provided up to the maximum of 8 units Total Units = (3 base units plus time units) 		<ul style="list-style-type: none"> One time unit equals 15 minutes 00400 may only be billed with allowable BCCS facility codes
76098	Radiological examination, surgical specimen	\$17.04
<ul style="list-style-type: none"> May be billed to reflect each lesion present, up to the maximum of 3 per breast 		
76641	Ultrasound, <i>complete</i> examination of breast including axilla, unilateral	\$110.31
76642	Ultrasound, <i>limited</i> examination of the breast including axilla, unilateral	\$90.72
<ul style="list-style-type: none"> May not be billed with 76942. 76641 used when four quadrants of the breast are examined 		<ul style="list-style-type: none"> 76642 used when fewer than four quadrants of the breast are examined May be billed to reflect each breast examined
76942	Ultrasonic guidance for needle biopsy, radiological supervision and interpretation	\$62.42
<ul style="list-style-type: none"> May be billed to reflect each lesion present, up to the maximum of 3 per breast 		<ul style="list-style-type: none"> May only be billed with 19000. May not be billed with 76641, 76642.

CPT CODE	CODE DESCRIPTIONS	
BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES		
10022	Fine Needle Aspiration, with imaging guidance	\$145.08
<ul style="list-style-type: none">FNA is not a suitable diagnostic method to definitively determine a final diagnosis of breast cancer. May be reimbursed for evaluation of abnormal lymph nodes for breast cancer staging and may not be reimbursed to evaluate a breast mass		<ul style="list-style-type: none">10022 may be billed with 88173BCCS performs utilization review on this service
88173	Cytopathology Interpretation and Report of Fine Needle Aspiration	\$157.61
<ul style="list-style-type: none">FNA is not a suitable diagnostic method to definitively determine a final diagnosis of breast cancer88173 may be billed to evaluate the aspirate of each abnormal lymph node for the purpose of breast cancer staging		<ul style="list-style-type: none">88173 may <u>only</u> be billed with 1002288173 requires cytologic expertise
88305	Surgical pathology, gross and microscopic examination of breast biopsy not requiring microscopic evaluation of surgical margins	\$75.18
<ul style="list-style-type: none">88305 may be billed for up to 6 biopsy specimens per breast		

CPT CODE	CODE DESCRIPTIONS		RATE
BILLING GUIDELINES – CERVICAL SCREENING & DIAGNOSTIC SERVICES			
87624	HPV, high-risk type		\$47.80
<ul style="list-style-type: none">Used for cytology and HPV co-testing every 5 years for women ages 30 and over and management of specific abnormal Pap testsMust be ordered by a provider and not done as part of lab protocolWhen a conventional Pap test result is ASC-US, a follow-up office visit may be billed to collect the reflex HPV test		<ul style="list-style-type: none">When a liquid based Pap test result is ASC-US, the HPV test can be done on the original specimen and a follow-up visit for HPV testing cannot be billedRefer to cervical algorithms for indications for HPV testingHPV tests must be for high-risk oncogenic types, FDA approved and clinically validated	

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BILLING GUIDELINES – CERVICAL SCREENING & DIAGNOSTIC SERVICES		
88141	Pap Test – physician’s interpretation (Bethesda System)	\$33.42
<ul style="list-style-type: none"> Each laboratory may develop their own policy for indications for the pathologist's review of Pap slides Only abnormal or reparative/reactive Pap results, as determined by the cytotechnologist, can be reimbursed for physician review 		<ul style="list-style-type: none"> Bill with 88142, 88143, 88164, 88174, 88175 as the technical Pap test service The BCCS program monitors utilization. No greater than 5% of Pap tests provided by a contractor should require physician (pathologist) review
88142	Pap Test – liquid based, cytologist’s interpretation (Bethesda System)	\$27.60
<ul style="list-style-type: none"> Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines 		
88143	Pap Test-cytopathology, cervical, collected in preservative fluid, automated thin layer prep; manual screening and rescreening under physician supervision	\$27.60
<ul style="list-style-type: none"> Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines 		
88164	Pap Test – cytologist’s interpretation (Bethesda System)	\$14.39
<ul style="list-style-type: none"> As indicated. Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines 		
88174	Cytopathology, cervical, collected in preservative fluid, automated thin layer prep; screening by automated system under physician supervision	\$29.11
<ul style="list-style-type: none"> Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines 		
88175	Cytopathology, cervical, collected in preservative fluid, automated thin layer prep; screening by automated system and manual rescreening under physician supervision	\$36.09
<ul style="list-style-type: none"> Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines 		
88305	Surgical pathology, gross and microscopic examination of cervical biopsy	\$75.18
<ul style="list-style-type: none"> May be billed for up to 5 specimens to reflect 4 biopsy sites on the cervix & one (1) ECC biopsy 		
88307	Surgical Pathology, gross and microscopic examination (cervix, conization)	\$316.52
<ul style="list-style-type: none"> May be billed with 57461, 57520, 57522 and their associated facility codes 		<ul style="list-style-type: none"> May be billed for up to 4 specimens per cervical conization procedure

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL SCREENING & DIAGNOSTIC SERVICES		
57452	Colposcopy	\$111.98
<ul style="list-style-type: none"> May be billed only once regardless of the number of lesions 		<ul style="list-style-type: none"> Office visit codes on the day of the procedure are not payable (Global fee period 000)
57454	Colposcopy with cervical biopsy(s) and endocervical curettage (Physician in Office)	\$156.97
F7454	Colposcopy with cervical biopsy(s) and endocervical curettage (Physician in Facility)	\$139.92
454FX	Facility fee for colposcopy with cervical biopsy(s) and endocervical curettage	\$61.58
<ul style="list-style-type: none"> 57454 and F7454 may be billed only once regardless of the number of lesions 88305 may be billed for up to 5 specimens to reflect 4 biopsy sites on the cervix & one (1) ECC biopsy May not be billed with 88307 May not be billed with colposcopy: 57452, 57455, 57456, 57460, 57461 or their associated facility codes 00940 cannot be billed with 57454 		<ul style="list-style-type: none"> 00940 may be billed to reflect anesthesia provided, up to the 8 unit maximum 454FX may be billed once with F7454 Office visit codes on the day of the procedure are not payable (Global fee period 000) BCCS performs utilization review of F7454 and 454FX. Preauthorization is required
57455	Colposcopy with biopsy(s) of the cervix (Physician in Office)	\$146.44
F7455	Colposcopy with biopsy(s) of the cervix (Physician in Facility)	\$114.16
455FX	Facility fee for colposcopy with biopsy(s) of the cervix	\$64.81
<ul style="list-style-type: none"> May be billed only once, regardless of the number of lesions 88305 may be billed for up to 4 specimens to reflect multiple biopsy sites on cervix May not bill with 88307 May not be billed with colposcopy: 57452, 57454, 57456, 57460, 57461 or their associated facility codes F7455 may be billed once with 455FX 		<ul style="list-style-type: none"> 00940 cannot be billed with 57455 00940 may be billed to reflect anesthesia provided, up to the 8 unit maximum Office visit codes on the day of the procedure are not payable (Global fee period 000) BCCS performs utilization review of F7455 and 455FX. Preauthorization is required

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL SCREENING & DIAGNOSTIC SERVICES		
57456	Colposcopy with endocervical curettage (Physician in Office)	\$138.11
F7456	Colposcopy with endocervical curettage (Physician in Facility)	\$106.19
456FX	Facility fee for colposcopy with endocervical curettage	\$61.94
<ul style="list-style-type: none"> May be billed only once regardless of the number of lesions 88305 may only be billed once May not be billed with 88307 00940 cannot be billed with 57456 00940 may be billed to reflect anesthesia provided, up to the 8 unit maximum 		<ul style="list-style-type: none"> May not be billed with colposcopy: 57452, 57454, 57455, 57460, 57461 or their associated facility codes Office visit codes on the day of the procedure are not payable (Global fee period 000) F7456 may be billed once with 456FX BCCS performs utilization review of F7456 and 456FX. Preauthorization is required
57460	Colposcopy with loop electrode biopsy(s) of the cervix (Physician in Office)	\$289.68
F7460	Colposcopy with loop electrode biopsy(s) of the cervix (Physician in Facility)	\$167.81
460FX	Facility fee for colposcopy with loop electrode biopsy(s)	\$172.58
<ul style="list-style-type: none"> May be billed only once, regardless of the number of lesions May not be billed with colposcopy: 57452, 57454, 57455, 57456, 57461 or their associated facility codes 00940 cannot be billed for 57460 00940 may be billed to reflect anesthesia provided, up to the 8 unit maximum 88305 may be billed for up to 4 specimens to reflect multiple biopsy sites on the cervix 		<ul style="list-style-type: none"> May not bill with 88307 F7460 may be billed once with 460FX Office visit codes on the day of the procedure are not payable (Global fee period 000) BCCS performs utilization review of F7460 and 460FX. Preauthorization is required

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL SCREENING & DIAGNOSTIC SERVICES		
57461	Colposcopy with loop electrode conization of the cervix (Physician in Office)	\$327.36
F7461	Colposcopy with loop electrode conization of the cervix (Physician in Facility)	\$193.52
461FX	Colposcopy with loop electrode conization of the cervix (Facility Fee)	\$185.82
<ul style="list-style-type: none"> Office visit codes on the day of the procedure are not payable (Global fee period 000) May not be billed with colposcopy: 57452, 57454, 57455, 57456, 57460 and their associated facility codes 57461 may be billed only once and may not be billed with F7461, 461FX or anesthesia 88307 may be billed for up to 4 specimens 88305 may not be billed with 57461 or F7461 		<ul style="list-style-type: none"> F7461 may be billed once with 461FX 00940 may not be billed with 57461 00940 may be billed for the total units of anesthesia provided, up to the 8 unit maximum No greater than 20% of conization LEEPs should be done in a certified ambulatory surgical center or day surgery facility
57500	Biopsy(s) of cervix (Physician in Office)	\$130.88
<ul style="list-style-type: none"> 88305 may be billed with 57500 for up to 4 specimens to reflect multiple biopsy sites on cervix May not be billed with 88307 		<ul style="list-style-type: none"> Office visit codes on the day of the procedure are not payable (Global fee period 000)
57505	Endocervical curettage (Physician in Office)	\$104.74
<ul style="list-style-type: none"> May be billed only once 88305 may be billed once with 57505 May not be billed with 88307 		<ul style="list-style-type: none"> Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 010)

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL SCREENING & DIAGNOSTIC SERVICES		
57520	Conization of the cervix; excision by cold knife or laser (Physician in Facility)	\$283.65
520FX	Facility fee for conization of the cervix (excision by cold knife or laser method)	\$1,040.74
<ul style="list-style-type: none"> 57520 may be billed only once 88307 may be billed with 57520 for up to 4 specimens May not be billed with 88305 00940 may be billed for the units of anesthesia provided, up to the 8 unit maximum 57520 must be performed in a certified ambulatory surgery center or day surgery facility 		<ul style="list-style-type: none"> 520FX may be billed once with 57520 Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 090) BCCS performs utilization review of this service
57522	Conization of cervix (LEEP); (Physician in office)	\$270.02
F7522	Conization of cervix (LEEP); (Physician in Facility)	\$250.44
522FX	Facility fee for Conization of cervix (excision by LEEP method)	\$1,040.74
<ul style="list-style-type: none"> 57522 may be billed only once and may not be billed with F7522, 522FX or anesthesia May not be billed with colposcopy: 57452, 57454, 57455, 57456, 57460, 57461 or associated facility codes 88307 may be billed for up to 4 specimens May not be billed with 88305 F7522 may be billed only once with 522FX 		<ul style="list-style-type: none"> 00940 may be billed with F7522 for the total units of anesthesia provided, up to the 8 unit maximum No greater than 20% of conization LEEPs should be done in a certified ambulatory surgical center or day surgery facility Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 090). BCCS performs utilization review of this service
00940	Anesthesia for vaginal procedures (including biopsy of cervix); not otherwise specified.	\$22.88
<ul style="list-style-type: none"> Bill for the total number of units provided up to a maximum of 8 units Total Units = (3 base units plus time units). One time unit equals 15 minutes 		<ul style="list-style-type: none"> 00940 may only be billed with allowable BCCS procedures performed in a facility

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL SCREENING & DIAGNOSTIC SERVICES		
58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy; (list separately in addition to code for colposcopy) (Physician in Office)	\$49.31
F8110	Endometrial sampling (biopsy) performed in conjunction with colposcopy; (list separately in addition to code for colposcopy) (Physician in Facility)	\$42.05
<ul style="list-style-type: none"> Must be billed with a colposcopy: 57452, 57454, 57455, 57456, 57460, 57461 or their associated facility codes 00940 may not be billed with 58110 00940 may be billed to reflect anesthesia, up to the maximum of 8 units 		<ul style="list-style-type: none"> F8110 requires preauthorization Code related to another service and is always included in the global period of the other service (Global fee period ZZZ) Utilization review is performed on this service

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – PRE-OPERATIVE LABORATORY PROCEDURES FOR DIAGNOSTIC SERVICES		
93000	ECG	\$17.40
<ul style="list-style-type: none"> Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions.(ASA Grade 2 or 3) For BCCS diagnostic services only 		<ul style="list-style-type: none"> Refer to the American Society of Anesthesiologists for (ASA) grades. Utilization review is performed on this service
80048	Basic Metabolic Panel (Chem 6)	\$11.52
80053	Comprehensive Metabolic Panel (Chem 12)	\$14.39
<ul style="list-style-type: none"> Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions. (ASA Grade 2 or 3) For BCCS diagnostic services only 		<ul style="list-style-type: none"> 88048 may not be billed with 88053 No greater than 7% clients receiving anesthesia should undergo these tests. Utilization review is performed on these services

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – PRE-OPERATIVE LABORATORY PROCEDURES FOR DIAGNOSTIC SERVICES		
81025	Urine Pregnancy Test	\$8.61
<ul style="list-style-type: none"> Performed only prior to procedures utilizing general anesthetic for women of child-bearing age. May not be used as routine pregnancy screening 		<ul style="list-style-type: none"> For BCCS diagnostic services only BCCS performs utilization review on this service Contractors may be required to reimburse BCCS for CD125 billing not in accordance with billing guideline.
85025	CBC, automated with differential	\$10.59
85027	CBC, automated	\$8.81
<ul style="list-style-type: none"> Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions. (ASA grade 2 or 3) For BCCS diagnostic services only 		<ul style="list-style-type: none"> 85025 cannot be billed with 85027 No greater than 7% clients receiving anesthesia should undergo these tests. BCCS performs utilization review on these services
85610	Prothrombin Time (PT)	\$5.36
85730	Partial Thromboplastin Time (PTT)	\$8.18
85384	Fibrinogen	\$11.57
<ul style="list-style-type: none"> Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions. (ASA grades 2 or 3) For BCCS diagnostic services only 		<ul style="list-style-type: none"> 8610, 85730 and 85384 may be billed together No greater than 7% clients receiving anesthesia should undergo these tests. BCCS performs utilization review on these services
71010	Chest X-Ray, AP (1 View)	\$22.85
010FX	Facility fee for Chest X-Ray, AP (1 view)	\$12.89
71020	Chest X-Ray, AP and Lateral (2 views)	\$28.30
020FX	Facility fee for Chest X-Ray, AP and Lateral (2 views)	\$16.47
<ul style="list-style-type: none"> Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions. (ASA grades 2 or 3) For BCCS diagnostic services only 		<ul style="list-style-type: none"> 71010 and 010FX cannot be billed with 71020 or 020FX No greater than 7% clients receiving anesthesia should undergo these tests. BCCS performs utilization review on these services

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – PATIENT NAVIGATION SERVICES		
44410	Medicaid for Breast and Cervical Cancer (MBCC) Comprehensive Visit	\$122.31
<ul style="list-style-type: none"> 44410 may only be billed for a client diagnosed with breast or cervical cancer by a non-BCCS provider who is referred to your agency for completion of the MBCC application No BCCS screening or diagnostic funds were used for the cancer diagnosis 44410 may only be billed by one BCCS contractor, one time only per cancer diagnosis, upon completion of the MBCC assessment, service plan, and application Note: Completed MBCC applications shall not be submitted to HHSC until all client data and patient navigation billing has been entered into Med-IT 44410 reimbursement requires completion of the Med-IT patient navigation module 		<ul style="list-style-type: none"> 44410 may only be billed with 44413 and may not be billed with any other codes, including patient navigation codes: 99910, 99913, 88810, and 88813 May not be billed for a reinstatement, renewal, or client transferring from another state <u>If a contractor deliberately submits a MBCC application for a client that they knew was not eligible, HHSC may withhold or recover payment</u> May not be billed with SC100
44413	Medicaid for Breast and Cervical Cancer (MBCC) Telephone call (or in-person visit)	\$29.36
<ul style="list-style-type: none"> May be billed up to a maximum of 3 follow-up phone calls Note: Completed MBCC applications shall not be submitted to HHSC until all client data and patient navigation billing has been entered into Med-IT May not be billed with SC100 		
99910	Patient Navigation for abnormal breast cancer screening (abnormal CBE or mammogram, diagnostic tests required)	\$122.31
<ul style="list-style-type: none"> 99910 may only be billed by one BCCS contractor, one time only per problem, and upon completion of the assessment and service plan 99910 reimbursement requires completion of Med-IT patient navigation module 		<ul style="list-style-type: none"> May not bill with 44410, 44413, 88810 or 88813 May not be billed for a reinstatement, renewal, or client transferring from another state
99913	BCCS Follow-up Visit (telephone)	\$29.36
<ul style="list-style-type: none"> May be billed up to a maximum of 3 follow-up phone calls or in-person visits to conduct patient navigation activities May not bill with 44410, 44413, 88810 or 88813 		
SC100	Service Coordination	\$50.00
<ul style="list-style-type: none"> SC100 reimbursement requires insurance assessment with Marketplace referral and Med-IT documentation in <i>Cycle Initiation -> Insurance Referral</i> 'Marketplace Referral' types are variable by contractor and may include handouts, on-site assistance, counselor referrals, etc. 		<ul style="list-style-type: none"> May only be billed by one BCCS contractor, one time per year May not be billed for clients that are BCCS ineligible May not be billed for MBCC referred-in clients - 44410

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – PATIENT NAVIGATION SERVICES		
88810	Patient Navigation for abnormal cervical cancer screening (diagnostic test required)	\$122.31
<ul style="list-style-type: none"> 88810 may only be billed by one BCCS contractor, one time only per problem, and upon completion of the assessment and service plan 88810 reimbursement requires completion of Med-IT patient navigation module 		<ul style="list-style-type: none"> May not bill with 44410, 44413, 99910 or 99913 May not be billed for a reinstatement, renewal, or client transferring from another state
88813	Follow-up Visit (telephone)	\$29.36
<ul style="list-style-type: none"> May be billed up to a maximum of 3 follow-up phone calls or in-person visits to conduct patient navigation activities May not bill with 44410, 44413, 99910 or 99913 		

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)		
CD202	Office Visit - New Patient; <i>expanded problem focused</i> history, exam, straightforward decision-making; 20 minutes	\$76.20
CD203	Office Visit - New Patient; <i>detailed</i> history, exam, straightforward decision-making; 30 minutes	\$110.25
CD204	Office Visit - New Patient; <i>comprehensive</i> history, exam, moderate complexity decision-making; 45 minutes.	\$168.36
CD211	Office Visit - Established Patient; <i>evaluation and management</i> , may not require physician; 5 minutes	\$20.33
CD212	Office Visit - Established Patient; <i>problem focused</i> history, exam, straightforward decision-making; 10 minutes	\$44.27
CD213	Office Visit - Established Patient; <i>expanded problem focused</i> history, exam, low-complexity decision-making; 15 minutes	\$74.42
CD214	Office Visit - Established Patient; <i>detailed</i> history, exam, moderate complexity decision-making; 25 minutes	\$109.65
<ul style="list-style-type: none"> Office visits may only be billed for face-to-face interactions with a licensed, qualified provider, i.e. MD, APN, PA, or RN The "CD" code billed for an office visit should be based on the level of complexity of the history, exam, and decision-making CD204 & CD214 are uncommon office visits for typical services provided under Title V dysplasia Utilization review is performed on office visits No more than 1 office visit s billable on the same day CD211 does not require physician presence, although client evaluation and/or management are required; CD211 is not billable for client phone calls. Global fee periods apply to certain management and treatment procedures. Office visits are not allowed to be billed separately during some global fee periods See specific CD, FCD and FCX management & treatment procedure codes for any global fee periods that may apply Neither BCCS, nor the patient, can be billed for "no show" visits <p>NOTE: CD202 corresponds to 99202 CD203 corresponds to 99203 CD204 corresponds to 99204 CD212 corresponds to 99212 CD213 corresponds to 99213 CD214 corresponds to 99214</p>		

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)		
CD810	Patient Navigation for “Referred-In” to Dysplasia Treatment Services	\$122.31
<ul style="list-style-type: none"> CD810 may be billed for patient navigation services for a client who was referred-in for cervical dysplasia management & treatment CD810 may not be billed with 88810 or 88813 	<ul style="list-style-type: none"> CD810 may only be billed by one BCCS contractor, one time only, per problem, and upon completion of the assessment and service plan NOTE: CD810 corresponds to 88810 	
CD624	HPV, high-risk types	\$47.80
<ul style="list-style-type: none"> Use for management of dysplasia per dysplasia algorithms Must be ordered by a provider and not done as part of lab protocol 	<ul style="list-style-type: none"> HPV tests must be for high-risk oncogenic types, FDA approved and clinically validated NOTE: CD624 corresponds to 87624 	
CD141	Pap Test – Physician’s interpretation	\$33.42
<ul style="list-style-type: none"> May be billed as the professional component with CD142 and CD164 as applicable Each laboratory may develop their own policy for pathologist review of cervical Pap slides 	<ul style="list-style-type: none"> No greater than 5% of Pap tests provided should require pathologist review BCCS performs utilization review of this service 	
CD142	Pap Smear – liquid based	\$27.60
<ul style="list-style-type: none"> Use for management of dysplasia per cervical dysplasia algorithms NOTE: CD142 corresponds to 88142 		
CD164	Pap Smear– conventional	\$14.39
<ul style="list-style-type: none"> Use for management of dysplasia per dysplasia algorithms NOTE: CD164 corresponds to 88164 		

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)		
CD452	Colposcopy	\$111.98
<ul style="list-style-type: none"> May be billed only once Office visit codes on the day of the procedure are not payable (Global fee period 000). NOTE: CD452 corresponds to 57452 		
CD455	Colposcopy with biopsy(s) of the cervix (Physician in Office)	\$146.44
FCX55	Colposcopy with biopsy(s) of the cervix (Physician in Facility)	\$114.16
FCD55	Facility fee for colposcopy with biopsy(s) of the cervix	\$64.81
<ul style="list-style-type: none"> May be billed only once CD305 may be billed with CD455 and FCX55 up to 4 times to reflect multiple biopsy sites on the cervix Cannot be billed with colposcopy codes FCD55 may be billed once with FCX55 CD940 cannot be billed with CD455 CD940 may be billed to reflect anesthesia, up to the maximum of 8 units Office visit codes on the day of the procedure are not payable (Global fee period 000) BCCS performs utilization review on FCX55/FCD55. Preauthorization is required NOTE: CD455 corresponds to 57455 FCX55 corresponds to F7455 FCD55 corresponds to 455FX 		
CD456	Colposcopy with endocervical curettage (Physician in Office)	\$138.11
FCX56	Colposcopy with endocervical curettage (Physician in Facility)	\$106.19
FCD56	Facility fee for colposcopy with endocervical curettage	\$61.94
<ul style="list-style-type: none"> May be billed only once CD305 may be billed only once with CD456 and FCX56. Cannot be billed with colposcopy codes CD940 cannot be billed with CD456 CD940 can be billed to reflect anesthesia provided, up to the maximum of 8 FCD56 may be billed once with FCX56 Office visit codes on the day of the procedure are not payable (Global fee period 000) BCCS performs utilization review on FCX56/FCD56. Preauthorization is required NOTE: CD456 corresponds to 57456 FCX56 corresponds to F7456 FCD56 corresponds to 456FX 		

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)		
CD460	Colposcopy with loop electrode biopsy(s) of the cervix (Physician in Office)	\$289.68
FCX60	Colposcopy with loop electrode biopsy(s) of the cervix (Physician in Facility)	\$167.81
FCD60	Facility fee for colposcopy with loop electrode biopsy(s) of the cervix	\$172.58
<ul style="list-style-type: none"> May be billed only once CD305 may be billed with CD460 and FCS60 up to 4 times to reflect multiple biopsy sites on the cervix May not be billed with colposcopy codes FCD60 may be billed once with FCX60 CD940 cannot be billed with CD460 		<ul style="list-style-type: none"> CD940 can be billed to reflect anesthesia, up to the maximum of 8 units Office visit codes on the day of the procedure are not payable (Global fee period 000) BCCS performs utilization review on FCX60/FCD60. Preauthorization is required NOTE: CD460 corresponds to 57460 FCX60 corresponds to F7460 FCD60 corresponds to 460FX
CD461	Colposcopy with loop electrode conization of the cervix (Physician in Office)	\$327.36
FCX61	Colposcopy with loop electrode conization of the cervix (Physician in Facility)	\$193.52
FCD61	Facility fee for colposcopy with loop electrode conization of the cervix	\$185.82
<ul style="list-style-type: none"> May be billed only once CD307 may be billed up to 4 times to reflect multiple biopsy sites on the cervix May not be billed with colposcopy codes FCD61 may be billed once with FCX61 CD940 cannot be billed with CD461 		<ul style="list-style-type: none"> CD940 can be billed to reflect anesthesia, up to the maximum of 8 units Office visit codes on the day of the procedure are not payable (Global fee period 000) NOTE: CD461 corresponds to 57461 FCX61 corresponds to F7461 FCD61 corresponds to 461FX BCCS performs utilization review of FCX61 AND FCD61. Pre-authorization is required

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)		
CD454	Colposcopy with cervical biopsy(s) and endocervical curettage (Physician in Office)	\$156.97
FCX54	Colposcopy with cervical biopsy(s) and endocervical curettage (Physician in Facility)	\$139.92
FCD54	Facility fee for colposcopy with biopsy(s) and endocervical curettage	\$61.58
<ul style="list-style-type: none"> May be billed only once May not be billed with colposcopy codes CD305 may be billed up to 5 times to reflect 4 biopsy sites on the cervix and one (1) ECC biopsy CD940 cannot be billed with CD454 CD940 may be billed to reflect anesthesia, up to the maximum of 8 units. 		<ul style="list-style-type: none"> FCD54 may be billed once with FCX54 Office visit codes on the day of the procedure are not payable (Global fee period 000) BCCS performs utilization review on FCX54/FCD54. Preauthorization is required NOTE: CD454 corresponds to 57454 FCX54 corresponds to F7454 FCD54 corresponds to 454FX
CD505	Endocervical curettage (Physician in Office)	\$104.74
<ul style="list-style-type: none"> May be billed only once. CD305 may be billed once with CD505. May not be billed with CD307. 		<ul style="list-style-type: none"> Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 010).
CD511	Cryotherapy: cryocautery, initial or repeat	\$148.65
<ul style="list-style-type: none"> There is no pathology associated with CD511 because a biopsy is not performed with this procedure Decision to repeat is based upon provider medical decision-making and adherence to algorithms 		<ul style="list-style-type: none"> Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 010) NOTE: CD511 corresponds to 57511 BCCS performs utilization review of this service
CD513	Cervical Cautery with laser ablation	\$148.91
<ul style="list-style-type: none"> There is no pathology associated with CD513 because a biopsy is not performed with this procedure Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 010) 		<ul style="list-style-type: none"> NOTE: CD513 corresponds to 57513 BCCS performs utilization review of this service

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)		
FCX20	Cervical Conization with cold knife or laser (Physician in Facility)	\$ 283.65
FCD20	Facility fee for Cervical Conization with cold knife or laser	\$1,040.74
<ul style="list-style-type: none"> FCX20 must be performed in a certified ambulatory surgical center or a day surgery facility FCX20 may be billed only once FCD20 may be billed with FCX20 for the facility fee CD307 may be billed with FCX20 for up to 4 specimens per cervical conization procedure Cannot be billed with CD305 		<ul style="list-style-type: none"> CD940 may be billed for the total units of anesthesia provided during the procedure, up to the 8 unit maximum Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 090) NOTE: FCX20 corresponds to 57520 FCD20 corresponds to 520FX BCCS performs utilization review of this service
CD522	Cervical Conization with Loop Electrode Excision (LEEP) (Physician in Office)	\$270.02
FCX22	Cervical Conization with Loop Electrode Excision (LEEP) (Physician in Facility)	\$250.44
FCD22	Facility fee for Cervical Conization with Loop Electrode Excision (LEEP)	\$1,040.74
<ul style="list-style-type: none"> CD522 may be billed only once and cannot be billed with FCX22, FCD22, or CD940 CD522 and FCX22 may not be billed with CD452, CD454, CD455, CD456, CD460, CD461 or their associated facility codes CD307 may be billed with CD522 or FCX22 for up to 4 specimens May not be billed with CD305 FCD22 may be billed once with FCX22. CD940 may be billed for the total units of anesthesia provided during the procedure, up to the 8 unit maximum No greater than 20% of conization LEEPs should be done in a certified, ambulatory surgical center or a day surgery facility 		<ul style="list-style-type: none"> Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 090) NOTE: CD522 corresponds to 57522 FCX22 corresponds to F7522 FCD22 corresponds to 522FX BCCS performs utilization review of this service

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)		
CD811	Endometrial sampling (biopsy) performed in conjunction with colposcopy; (list separately in addition to code for colposcopy) (Physician in Office)	\$49.31
FCX81	Endometrial sampling (biopsy) performed in conjunction with colposcopy; (list separately in addition to code for colposcopy) (Physician in Facility)	\$42.05
<ul style="list-style-type: none"> May be billed only once CD811 must be billed with a colposcopy Reimbursable only after Pap test result of Atypical Glandular Cells (AGC) or greater if: <ul style="list-style-type: none"> Client 35 or more years of age, or At risk for endometrial neoplasia (see BCCS algorithms). CD940 cannot be billed with CD811 CD940 may be billed to reflect anesthesia, up to the maximum of 8 units 		<ul style="list-style-type: none"> Code related to another service and is always included in the global period of the other service (Global fee period ZZZ). Utilization review is performed on this service Pre-authorization is required for FCX81
CD940	Anesthesia for vaginal procedures (including biopsy of cervix); not otherwise specified.	\$22.88
<ul style="list-style-type: none"> Bill for the total number of units provided, up to the 8 unit maximum. Total Units= (3 base units plus time units). One time unit equals 15 minutes 		<ul style="list-style-type: none"> CD940 may only be billed with allowable facility codes FCD20 or FCD22. NOTE: CD940 corresponds to 00940
CD305	Surgical Pathology - cervical biopsy	\$75.18
<ul style="list-style-type: none"> May be billed for up to 5 specimens to reflect 4 biopsy sites on the cervix and 1 ECC biopsy May only be billed once with CD505 NOTE: CD305 corresponds to 88305 		
CD307	Surgical Pathology – cervical conization	\$316.52
<ul style="list-style-type: none"> May be billed for up to 4 specimens per cervical conizations procedure. NOTE: CD307 corresponds to 88307 		
CD930	ECG	\$17.40
<ul style="list-style-type: none"> Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grade 2 or 3) For CD treatment services only 		<ul style="list-style-type: none"> Utilization review is performed on this service CD930 corresponds to 93000

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)		
CD048	Basic Metabolic Panel (Chem 6)	\$11.52
CD053	Comprehensive Metabolic Panel (Chem 12)	\$14.39
<ul style="list-style-type: none"> Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grades 2 or 3) CD048 cannot be billed with CD053 For CD treatment services only 	<ul style="list-style-type: none"> Utilization review is performed on this service CD048 corresponds to 80048 CD053 corresponds to 88053 	
CD125	Urine Pregnancy Test	\$8.61
<ul style="list-style-type: none"> Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grades 2 or 3) For CD treatment services only 	<ul style="list-style-type: none"> Utilization review is performed on this service CD125 corresponds to 81025 Contractors may be required to reimburse BCCS for CD125 billing not in accordance with billing guideline. 	
CD025	CBC, automated with differential	\$10.59
CD027	CBC, automated	\$8.81
<ul style="list-style-type: none"> Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grades 2 or 3) For CD treatment services only CD025 corresponds to 85025 	<ul style="list-style-type: none"> CD025 cannot be billed with CD027 CD027 corresponds to 85027 	
CD610	Prothrombin Time (PT)	\$5.36
CD730	Partial Prothrombin Time (PTT)	\$8.18
CD384	Fibrinogen	\$11.57
<ul style="list-style-type: none"> Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grades 2 or 3) For CD treatment services only CD610, CD730 and CD384 may be billed together BCCS performs utilization review on this service 	<ul style="list-style-type: none"> CD610 corresponds to 85610 CD730 corresponds to 85730 CD384 corresponds to 85384 	

CPT CODE	CODE DESCRIPTIONS		RATE
BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)			
CD710	Chest X-Ray, AP (1 view)		\$22.85
FCD01	Facility fee for Chest X-Ray, AP (1 view)		\$12.89
CD720	Chest X-Ray, AP and Lateral (2 views)		\$28.30
FCD02	Facility fee for Chest X-Ray, AP and Lateral (2 views)		\$16.47
<ul style="list-style-type: none">Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grades 2 or 3)For CD treatment services onlyCD710 and FCD01 cannot be billed with CD720 or FCD02BCCS performs utilization review of these services		<ul style="list-style-type: none">CD710 corresponds to 71010FCD01 corresponds to 010FXCD720 corresponds to 71020FCD02 corresponds to 020FX	